



Maternal Health Postpartum Visit Only

Client ID: _____

Admission ID: _____

Client's name (first, middle, last): _____ Maiden name: _____

Client alias: _____ Alias Client ID: _____

Birth date: ____/____/____ Medicaid ID: _____ Other IDs: _____

ID Number	ID Type

Street address: _____ Apt# _____ County: _____

City: _____ State: _____ Zip code: _____

Cell phone: _____ Alternate phone: _____

Emergency contact: _____ Phone: _____ Relationship: _____

Primary Race: (enter option from race table below) _____

Race:

(Check all that apply)

- | | | |
|--|--|----------------------------------|
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Black | <input type="checkbox"/> unknown |
| <input type="checkbox"/> Asian | <input type="checkbox"/> Native Hawaiian/Other Pacific | <input type="checkbox"/> other |
| | <input type="checkbox"/> White | specify _____ |

Is participant of Hispanic/Latino descent? ☐ yes ☐ noCountry of Origin:
(if Hispanic/Latino)

- | | | | |
|--|--------------------------------------|--|--------------------------------|
| <input type="checkbox"/> Central America | <input type="checkbox"/> Mexico | <input type="checkbox"/> South America | <input type="checkbox"/> other |
| <input type="checkbox"/> Cuba | <input type="checkbox"/> Puerto Rico | <input type="checkbox"/> Unknown | specify _____ |

Ethnicity:

- | | | | |
|---|---|--|-----------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Asian (Burmese) | <input type="checkbox"/> Haitian | <input type="checkbox"/> Somalian |
| <input type="checkbox"/> African (not Sudanese) | <input type="checkbox"/> Asian (Vietnamese) | <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> unknown |
| <input type="checkbox"/> African (Sudanese) | <input type="checkbox"/> Bosnian | <input type="checkbox"/> Jamaican | <input type="checkbox"/> other |
| <input type="checkbox"/> American | <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean | specify _____ |
| <input type="checkbox"/> Asian (other) | <input type="checkbox"/> Croatian | <input type="checkbox"/> Micronesian | |

Languages spoken:

- | | | | |
|---|----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> American Sign Language | <input type="checkbox"/> English | <input type="checkbox"/> Sudanese | <input type="checkbox"/> other specify _____ |
| <input type="checkbox"/> Bosnian | <input type="checkbox"/> Serbian | <input type="checkbox"/> Vietnamese | |
| <input type="checkbox"/> Chinese | <input type="checkbox"/> Spanish | <input type="checkbox"/> unknown | |

Is English the primary language? ☐ yes ☐ no ☐ unknownIs a translator needed? ☐ yes ☐ no ☐ unknown If yes, what language? _____

Date of contact: _____

How did client hear of services? (choose all that apply)

- | | | |
|---|---|---|
| <input type="checkbox"/> birthright | <input type="checkbox"/> primary care provider | <input type="checkbox"/> hospital (specify) _____ |
| <input type="checkbox"/> education/school/AEA | <input type="checkbox"/> school nurse/counselor | <input type="checkbox"/> other (specify) _____ |
| <input type="checkbox"/> family planning | <input type="checkbox"/> shelter | |
| <input type="checkbox"/> friend/relative | <input type="checkbox"/> walk-in /self-referral | |
| <input type="checkbox"/> medical clinic | <input type="checkbox"/> WIC | |
| <input type="checkbox"/> other participant | <input type="checkbox"/> unknown | |

Will services be provided? ☐ yes ☐ no

If no, reason not served:

- | | | |
|---|---|--------------------------------|
| <input type="checkbox"/> eligibility guidelines not met | <input type="checkbox"/> not pregnant | <input type="checkbox"/> other |
| <input type="checkbox"/> out of service area | <input type="checkbox"/> services refused | specify _____ |

Client consent form signed? ☐ yes ☐ no

Date signed: ____/____/____

Subcontractor assigned: _____ County Assigned _____

Client Name: _____ Birth Date: _____ Medicaid ID: _____

Primary Payment Source: (enter option from payment source table below) _____

Secondary
Payment source:
(check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> private insurance | <input type="checkbox"/> uninsured |
| <input type="checkbox"/> Medicaid/Title XIX | <input type="checkbox"/> self-pay/sliding scale | <input type="checkbox"/> other specify _____ |
| <input type="checkbox"/> presumptive eligibility | <input type="checkbox"/> Title V | |

WIC certified? ☐ yes ☐ no ☐ unknown

Employment: ☐ full time ☐ part time ☐ unemployed

Current marital status:

- | | | |
|-----------------------------------|------------------------------------|----------------------------------|
| <input type="checkbox"/> divorced | <input type="checkbox"/> separated | <input type="checkbox"/> widowed |
| <input type="checkbox"/> married | <input type="checkbox"/> single | <input type="checkbox"/> unknown |

Highest grade participant completed:

- | | | |
|--|---|---|
| <input type="checkbox"/> 8th grade or less | <input type="checkbox"/> high school graduate | <input type="checkbox"/> college degree |
| <input type="checkbox"/> 9th grade | <input type="checkbox"/> GED | <input type="checkbox"/> technical training |
| <input type="checkbox"/> 10th grade | <input type="checkbox"/> some college | <input type="checkbox"/> other |
| <input type="checkbox"/> 11th grade | | |

How many children does client have? _____ Age range of children: _____

How many children are living in the home? _____

Father Information

Record name of baby's father and choose the code from the tables below to indicate race, ethnicity, relationship and insurance status. If the father's name is not available enter "unknown".

Name: _____

Race:

- | | | |
|--|--|--------------------------------|
| <input type="checkbox"/> American Indian/Alaska Native | <input type="checkbox"/> Native Hawaiian/Other Pacific | <input type="checkbox"/> other |
| <input type="checkbox"/> Asian | <input type="checkbox"/> White | specify _____ |
| <input type="checkbox"/> Black | <input type="checkbox"/> unknown | |

Ethnicity:

- | | | | |
|---|---|--|-----------------------------------|
| <input type="checkbox"/> African American | <input type="checkbox"/> Asian (Burmese) | <input type="checkbox"/> Haitian | <input type="checkbox"/> Somalian |
| <input type="checkbox"/> African (not Sudanese) | <input type="checkbox"/> Asian (Vietnamese) | <input type="checkbox"/> Hispanic/Latino | <input type="checkbox"/> unknown |
| <input type="checkbox"/> African (Sudanese) | <input type="checkbox"/> Bosnian | <input type="checkbox"/> Jamaican | <input type="checkbox"/> other |
| <input type="checkbox"/> American | <input type="checkbox"/> Chinese | <input type="checkbox"/> Korean | specify _____ |
| <input type="checkbox"/> Asian (other) | <input type="checkbox"/> Croatian | <input type="checkbox"/> Micronesian | |

Relationship: ☐ spouse ☐ significant other ☐ other relative ☐ other

Living with participant? ☐ yes ☐ no ☐ unknown

Involved with pregnancy/child? ☐ yes ☐ no ☐ unknown

Employed? ☐ yes ☐ no ☐ unknown

Comments: _____

Client Name: _____ Birth Date: _____ Medicaid ID: _____

Pregnancy Information

Has the client been seen at any other agency with this pregnancy? ☐ yes ☐ no ☐ unknown

Was this a planned pregnancy? ☐ yes ☐ no ☐ unknown

When was pregnancy first identified? ☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester ☐ unknown

When was first care received? ☐ pre conception ☐ 1st trimester ☐ 2nd trimester ☐ 3rd trimester ☐ no care

Outcome Information

Discharge date: ____/____/____ Will client receive postpartum home visit? ☐ yes ☐ no

Date postpartum referral was sent: ____/____/____ Date of postpartum home visit completion: ____/____/____

Attending parenting education classes? ☐ yes ☐ no

Delivery date ____/____/____

Multiple birth? ☐ yes ☐ no How many births? _____

Complications with this pregnancy? ☐ yes ☐ no

Did mother begin breastfeeding? ☐ yes ☐ no ☐ unknown

Pregnancy Comments:

Child Information

	Child #1	Child #2 (twin)	Child #3 (triplet)
Child's name (first, middle, last)			
Gender	<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> male <input type="checkbox"/> female	<input type="checkbox"/> male <input type="checkbox"/> female
Birthdate	____/____/____	____/____/____	____/____/____
Gestational age at birth (weeks)			
Outcome	<input type="checkbox"/> live birth <input type="checkbox"/> stillborn	<input type="checkbox"/> live birth <input type="checkbox"/> stillborn	<input type="checkbox"/> live birth <input type="checkbox"/> stillborn
Type of delivery	<input type="checkbox"/> vaginal <input type="checkbox"/> cesarean	<input type="checkbox"/> vaginal <input type="checkbox"/> cesarean	<input type="checkbox"/> vaginal <input type="checkbox"/> cesarean
Birthweight (grams)			
Length			
ID ID Type			
Abnormalities or health problems	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Describe health problem			
Has child died?	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes <input type="checkbox"/> no
Date of death	____/____/____	____/____/____	____/____/____

Client Name: _____ Birth Date: _____ Medicaid ID: _____

Does client smoke cigarettes? ☐ yes ☐ no ☐ unknown

How many cigarettes per day?

- | | | |
|-------------------------------|------------------------------------|--|
| <input type="checkbox"/> <1 | <input type="checkbox"/> 10-20 | <input type="checkbox"/> more than 2 packs |
| <input type="checkbox"/> 1-5 | <input type="checkbox"/> 1 pack | <input type="checkbox"/> unknown |
| <input type="checkbox"/> 5-10 | <input type="checkbox"/> 1-2 packs | |

Does client drink alcohol?

☐ yes ☐ no ☐ unknown

How often ?

☐ never ☐ less than 1 drink/week ☐ 2-6 drinks/week ☐ 1 drink/day ☐ more than 1 drink/day

Does client use illicit drugs?

☐ yes ☐ no ☐ unknown ☐ client declines

What drugs ?

- | | | |
|----------------------------------|--|----------------------------------|
| <input type="checkbox"/> cocaine | <input type="checkbox"/> heroin | <input type="checkbox"/> unknown |
| <input type="checkbox"/> crack | <input type="checkbox"/> marijuana | <input type="checkbox"/> other |
| <input type="checkbox"/> crank | <input type="checkbox"/> methamphetamine | specify _____ |

Was client screened for domestic abuse?

☐ yes ☐ no ☐ unknown

Was client screened for substance abuse?

☐ yes ☐ no ☐ unknown

Was client screened for depression?

☐ yes ☐ no ☐ unknown

Family planning arrangements:

- | | | | |
|--|---|--------------------------------|--|
| <input type="checkbox"/> birth control pills | <input type="checkbox"/> monthly injection (Depo) | <input type="checkbox"/> patch | <input type="checkbox"/> other specify _____ |
| <input type="checkbox"/> condom | <input type="checkbox"/> natural family planning | <input type="checkbox"/> ring | |
| <input type="checkbox"/> IUD | <input type="checkbox"/> Nexplanon | <input type="checkbox"/> none | |

Does client have a primary maternal care provider? (medical home)

☐ yes ☐ no ☐ unknown

Does client have regular dentist? ☐ yes ☐ no ☐ unknown

Name of dentist: _____

When was last dentist visit? ☐ Within 1 year ☐ 1-3 years ago ☐ More than 3 years ago ☐ Never seen a dentist ☐ Unknown

Barriers to dental care:

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Cost | <input type="checkbox"/> Office hours | <input type="checkbox"/> Other specify _____ |
| <input type="checkbox"/> Dentist will not accept Medicaid | <input type="checkbox"/> Fear | |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> None | |

Dental payment source:

- | | | |
|---|---|--|
| <input type="checkbox"/> Medicaid/Title XIX | <input type="checkbox"/> self-pay/sliding scale | <input type="checkbox"/> other specify _____ |
| <input type="checkbox"/> presumptive eligibility | <input type="checkbox"/> Title V | |
| <input type="checkbox"/> private dental insurance | <input type="checkbox"/> uninsured | |

Did client have dentist visit during pregnancy? ☐ yes ☐ no ☐ unknown

If yes, what was reason(s) for dentist visit? ☐ Regular check-up or teeth cleaning ☐ Treatment for pain or other problem ☐ unknown

Does client understand the need for her child to have a dentist visit by age 1? ☐ yes ☐ no

Does client have any oral concerns or problems? ☐ yes ☐ no

Specify: _____

Dental comments: _____

General comments: _____

	Name	Date
Outcome form completed by:		
Data entered by:		
Quality assurance inspection:		